		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022111

Facility Name: Glen Oaks Nursing Home

Address: 270 Skokie Highway (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 498-9320 **Fax #** (847) 498-2990

IDPA ID Number: 362847148001

Date of Initial License for Current Owners: 12/01/1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Altschuler, Melvoin and Glasser

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	164	Skilled (SNF)	164	60,024	1
2		Skilled Pediatric (SNF/PED)			2
3	134	Intermediate (ICF)	134	49,044	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	298	109,068	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,216	619	5,117	19,952	8
9	SNF/PED					9
10	ICF	73,041	2,834	2,476	78,351	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	87,257	3,453	7,593	98,303	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.13%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]
Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/75

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/15/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 3578

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 10/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	337,233	75,043	9,437	421,713		421,713	0	421,713			1
2	Food Purchase		545,356		545,356	(23,030)	522,326	(7,038)	515,288			2
3	Housekeeping	242,286	83,530		325,816		325,816	0	325,816			3
4	Laundry	128,368	13,374	28,905	170,647		170,647	0	170,647			4
5	Heat and Other Utilities			197,689	197,689		197,689	8,745	206,434			5
6	Maintenance	115,205	42,028	155,116	312,349		312,349	17,351	329,700			6
7	Other (specify):*							0				7
8	TOTAL General Services	823,092	759,331	391,147	1,973,570	(23,030)	1,950,540	19,058	1,969,598			8
	B. Health Care and Programs											
9	Medical Director			12,510	12,510		12,510	0	12,510			9
10	Nursing and Medical Records	2,920,877	502,788	2,637	3,426,302		3,426,302	(182,262)	3,244,040			10
10a	Therapy		1,651	118,081	119,732		119,732	0	119,732			10a
11	Activities	56,563	12,048	2,740	71,351		71,351	0	71,351			11
12	Social Services	128,510		2,720	131,230		131,230	0	131,230			12
13	Nurse Aide Training					1,300	1,300	0	1,300			13
14	Program Transportation			1,510	1,510		1,510	0	1,510			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	3,105,950	516,487	140,198	3,762,635	1,300	3,763,935	(182,262)	3,581,673			16
	C. General Administration											
17	Administrative	205,646		320,146	525,792		525,792	(320,146)	205,646			17
18	Directors Fees							0				18
19	Professional Services			157,365	157,365	(900)	156,465	7,140	163,605			19
20	Dues, Fees, Subscriptions & Promotions			27,327	27,327		27,327	2,006	29,333			20
21	Clerical & General Office Expenses	419,740	69,274	39,510	528,524		528,524	55,024	583,548			21
22	Employee Benefits & Payroll Taxes			583,120	583,120	23,030	606,150	61,847	667,997			22
23	Inservice Training & Education			2,135	2,135	(400)	1,735	721	2,456			23
24	Travel and Seminar							1,806	1,806			24
25	Other Admin. Staff Transportation			14,007	14,007		14,007	2,136	16,143			25
26	Insurance-Prop.Liab.Malpractice			82,468	82,468		82,468	2,441	84,909			26
27	Other (specify):*							0				27
28	TOTAL General Administration	625,386	69,274	1,226,078	1,920,738	21,730	1,942,468	(187,025)	1,755,443			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,554,428	1,345,092	1,757,423	7,656,943		7,656,943	(350,229)	7,306,714			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			182,794	182,794		182,794	144,308	327,102			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			65	65		65	428,780	428,845			32
33	Real Estate Taxes							337,943	337,943			33
34	Rent-Facility & Grounds			1,920,094	1,920,094		1,920,094	(1,920,094)				34
35	Rent-Equipment & Vehicles			18,484	18,484		18,484	10,877	29,361			35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			2,121,437	2,121,437		2,121,437	(998,186)	1,123,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		267,372	17,442	284,814		284,814	0	284,814			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			163,152	163,152		163,152	0	163,152			42
43	Other (specify):* Non-Allowable			87,721	87,721		87,721	(87,721)				43
44	**TOTAL Special Cost Centers**		267,372	268,315	535,687		535,687	(87,721)	447,966			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,554,428	1,612,464	4,147,175	10,314,067	0	10,314,067	(1,436,136)	8,877,931			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(141,431)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(847)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(55,710)	43		19
20	Contributions	(2,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	26,512	43		24
25	Fund Raising, Advertising and Promotional	(8,819)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(39,000)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,521)	43		28
29	Other-Attach Schedule See Attached Schedule F	(214,326)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (443,142)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(992,994)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (992,994)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,436,136)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X	99,277	Line 39	44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 99,277		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name Glen Oaks Nursing Home
ID# 0022111
Report Period Beginning: 1/01/2000
Ending: 12/31/2000

Print Other Adjustments

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(7,038)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	1,357
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	(5,681)
9	Non-Straightline Depreciation	0	0	Line 9	0
10	Interest and Other Investment Income	(141,431)	32	Line 10	(182,262)
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	(847)	43	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	(182,262)
18	Fines and Penalties	0	0	Line 17	0
19	Entertainment	(55,710)	43	Line 18	0
20	Contributions	(2,000)	43	Line 19	(26,047)
21	Owner or Key-Man Insurance	0	0	Line 20	0
22	Special Legal Fees & Legal Retainers	0	0	Line 21	0
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	26,512	43	Line 23	0
25	Fund Raising, Advertising and Promotional	(8,819)	43	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	(39,000)	43	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	(7,521)	43	Line 27	0
29	Non-Paid Workers	0	0	Line 28	(26,047)
30	Donated Goods	0	0	Line 29	(213,990)
31	Amortization Expense	0	0	Line 30	0
32	Adj. Management Comp. Medical Supplies 'A' To Cost	(68,065)	10	Line 31	0
33	Adj. Management Comp. Medical Supplies 'Other' To Cost	(114,197)	10	Line 32	(141,431)
34	Adj. Management Comp. Food To Cost	(7,038)	2	Line 33	0
35	Non-allowable Professional Fees	(26,047)	19	Line 34	0
36	Defer 2000 Painting and Decorating	(45,159)	6	Line 35	0
37	Amortization of Current Year Deferred Maintenance	46,516	6	Line 36	0
38	Patient Clothing	(336)	43	Line 37	(141,431)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	(87,721)
45				Line 44	(87,721)
46				Line 45	(443,142)

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Glen Oaks Nursing Home **#** 0022111 **Report Period Beginning:** 1/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,038)	0	0	0	0	0	0	0	0	0	0	(7,038)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	8,745	0	0	0	0	0	0	0	0	8,745	5
6	Maintenance	1,357	0	15,994	0	0	0	0	0	0	0	0	17,351	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,681)	0	24,739	0	0	0	0	0	0	0	0	19,058	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(182,262)	0	0	0	0	0	0	0	0	0	0	(182,262)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(182,262)	0	0	0	0	0	0	0	0	0	0	(182,262)	16
	C. General Administration													
17	Administrative	0	0	(320,146)	0	0	0	0	0	0	0	0	(320,146)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,047)	0	33,187	0	0	0	0	0	0	0	0	7,140	19
20	Fees, Subscriptions & Promotions	0	0	2,006	0	0	0	0	0	0	0	0	2,006	20
21	Clerical & General Office Expenses	0	0	42,224	12,800	0	0	0	0	0	0	0	55,024	21
22	Employee Benefits & Payroll Taxes	0	0	61,847	0	0	0	0	0	0	0	0	61,847	22
23	Inservice Training & Education	0	0	721	0	0	0	0	0	0	0	0	721	23
24	Travel and Seminar	0	0	1,806	0	0	0	0	0	0	0	0	1,806	24
25	Other Admin. Staff Transportation	0	0	2,136	0	0	0	0	0	0	0	0	2,136	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,441	0	0	0	0	0	0	0	0	2,441	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,047)	0	(173,778)	12,800	0	0	0	0	0	0	0	(187,025)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(213,990)	0	(149,039)	12,800	0	0	0	0	0	0	0	(350,229)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	34,403	109,905	0	0	0	0	0	0	0	144,308	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(141,431)	0	37,009	533,202	0	0	0	0	0	0	0	428,780	32
33	Real Estate Taxes	0	0	13,139	324,804	0	0	0	0	0	0	0	337,943	33
34	Rent-Facility & Grounds	0	0	0	(1,920,094)	0	0	0	0	0	0	0	(1,920,094)	34
35	Rent-Equipment & Vehicles	0	0	10,877	0	0	0	0	0	0	0	0	10,877	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(141,431)	0	95,428	(952,183)	0	0	0	0	0	0	0	(998,186)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(87,721)	0	0	0	0	0	0	0	0	0	0	(87,721)	43
44	**TOTAL Special Cost Centers**	(87,721)	0	0	0	0	0	0	0	0	0	0	(87,721)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(443,142)	0	(53,611)	(939,383)	0	0	0	0	0	0	0	(1,436,136)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Glen Oaks Nursing Home # 0922111 Report Period Beginning: 1/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sidney Gleiser	100.00 %	GlenBridge Nursing & Rehabilitation Centre,Ltd	Niles	SEE ATTACHED SCHEDULE A		
		GlenCrest Nursing & Rehabilitation Centre,Ltd	Chicago			
		Glen Elston Nursing & Rehabilitation Centre,Ltd	Chicago			
		Glenshire Nursing & Rehabilitation Centre,Ltd	Richton Park			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							1
2	V	From Page 6A	328,146	Glen Health and Home Management, Inc.	A	266,535	(53,611)	2
3	V							3
4	V	From Page 6B	1,920,094	Glen Oaks Real Estate and Development, L.L.C.	B	980,711	(939,383)	4
5	V							5
6	V							6
7	V							7
8	V			OWNERSHIP REFERENCE:				8
9	V			A. Sidney Gleiser - 41.50 %				9
10	V			B. Sidney Gleiser - 60.00 % (constructively)				10
11	V							11
12	V							12
13	V							13
14	Total		2,248,240			1,247,246	(992,994)	14

Sum_6

-53611

-939383

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPOR

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	17	Management Fees	$ 320,146	Glen Health and Home Management, Inc.	A	$	$ (320,146)	15	-320146
16	V	5	Utilities		Glen Health and Home Management, Inc.	A	8,745	8,745	16	8745
17	V	6	Repairs and Maintenance		Glen Health and Home Management, Inc.	A	15,994	15,994	17	15994
18	V	19	Professional Fees		Glen Health and Home Management, Inc.	A	33,187	33,187	18	33187
19	V	20	Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	2,006	2,006	19	2006
20	V	21	Clerical		Glen Health and Home Management, Inc.	A	42,224	42,224	20	42224
21	V	22	Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	61,847	61,847	21	61847
22	V	23	Training and Education		Glen Health and Home Management, Inc.	A	721	721	22	721
23	V	32	Amortization of Mortgage Cost		Glen Health and Home Management, Inc.	A	386	386	23	386
24	V	25	Auto Expenses		Glen Health and Home Management, Inc.	A	2,136	2,136	24	2136
25	V	26	Insurance		Glen Health and Home Management, Inc.	A	2,441	2,441	25	2441
26	V	30	Depreciation		Glen Health and Home Management, Inc.	A	34,403	34,403	26	34403
27	V	32	Interest		Glen Health and Home Management, Inc.	A	36,623	36,623	27	36623
28	V	33	Real Estate Taxes		Glen Health and Home Management, Inc.	A	13,139	13,139	28	13139
29	V	35	Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	10,877	10,877	29	10877
30	V	24	Travel		Glen Health and Home Management, Inc.	A	1,806	1,806	30	1806
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 320,146			$ 266,535	$ * (53,611)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

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Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	21	Bond Fees	$	Glen Oaks Real Estate and Development, L.L.C.	B	$ 2,500	$ 2,500	15	2500
16	V	21	Office Supplies		Glen Oaks Real Estate and Development, L.L.C.	B	10,300	10,300	16	10300
17	V	30	Depreciation		Glen Oaks Real Estate and Development, L.L.C.	B	109,905	109,905	17	109905
18	V	32	Interest Expense		Glen Oaks Real Estate and Development, L.L.C.	B	554,212	554,212	18	554212
19	V	32	Interest Income		Glen Oaks Real Estate and Development, L.L.C.	B	(28,686)	(28,686)	19	-28686
20	V	32	Amortization of Mortgage Costs		Glen Oaks Real Estate and Development, L.L.C.	B	7,676	7,676	20	7676
21	V	33	Real Estate Taxes		Glen Oaks Real Estate and Development, L.L.C.	B	324,804	324,804	21	324804
22	V	34	Rental Income	1,920,094	Glen Oaks Real Estate and Development, L.L.C.	B		(1,920,094)	22	-1920094
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 1,920,094			$ 980,711	$ * (939,383)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sidney Glenner	President	Administrative	100.00 %	103,383	13	22.00 %	Salary	$ 31,617	Ln 17, Col 1	1
2	Barry Ray	Vice President	Administrative	0.00 %	77,537	9	23.00 %	Salary	23,713	Ln 17, Col 1	2
3	David Glenner	Vice President	Administrative	0.00 %	57,435	9	23.00 %	Salary	17,565	Ln 17, Col 1	3
4											4
5											5
6			See Schedule B								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 72,895		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Glen Health & Home Management, Inc.
Street Address: 5454 West Fargo
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 674-5454
Fax Number: (847) 674-8311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	5	Utilities	Patient Days	419,697	5	37,338		98,303	8,745	2
3	6	Repairs and Maintenance	Patient Days	419,697	5	68,287		98,303	15,994	3
4	19	Professional Fees	Patient Days	419,697	5	141,688		98,303	33,187	4
5	20	Licenses, Permits and Inspection	Patient Days	419,697	5	8,563		98,303	2,006	5
6	21	Clerical	Patient Days	419,697	5	180,270		98,303	42,224	6
7	22	Employee Benefits and Payroll	Patient Days	419,697	5	264,051		98,303	61,847	7
8	23	Training and Education	Patient Days	419,697	5	3,079		98,303	721	8
9	32	Amortization of Mortgage Cost	Patient Days	419,697	5	1,646		98,303	386	9
10	25	Auto Expenses	Patient Days	419,697	5	9,121		98,303	2,136	10
11	26	Insurance	Patient Days	419,697	5	10,420		98,303	2,441	11
12	30	Depreciation	Patient Days	419,697	5	146,881		98,303	34,403	12
13	32	Interest	Patient Days	419,697	5	156,358		98,303	36,623	13
14	33	Real Estate Taxes	Patient Days	419,697	5	56,094		98,303	13,139	14
15	35	Equipment and Vehicle Rental	Patient Days	419,697	5	46,437		98,303	10,877	15
16	24	Travel	Patient Days	419,697	5	7,709		98,303	1,806	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,137,942	$		$ 266,535	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	American National Bank		X	Mortgage	$41,667.00	12/16/1996	$ 9,200,000	$ 7,200,000	12/01/2011	.0550	$ 554,212	1
2	American National Bank		X	Amortization of mortgage costs							7,676	2
3							Mortgage interest allocated from Management Company:				37,009	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$41,667.00		$ 9,200,000	$ 7,200,000			$ 598,897	9
	B. Non-Facility Related*											
10									Interest Income Offset:		(170,117)	10
11									Miscellaneous Interest:		65	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (170,052)	14
15	TOTALS (line 9+line14)						$ 9,200,000	$ 7,200,000			$ 428,845	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	309,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	312,804	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,804	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	321,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ____ For 19 ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	324,804	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	299,722	8
1996	301,089	9
1997	303,074	10
1998	305,668	11
1999	312,804	12

See Attached Schedule H For Calculation Of 2000 Real Estate Tax Accrual.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Three

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	98,518	1985	$ 345,000	1
2	Allocated from Management Company:			22,140	2
3	TOTALS	98,518		$ 367,140	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	298		1985		$ 3,587,393	$	30	$ 119,580	$ 119,580	$ 1,913,279	4
5											5
6	Mgt Comp:				470,948			11,117	11,117		6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Leasehold Improvements			1980	7,274		65 months			7,274	9
10	Leasehold Improvements			1981	4,127		35 months			4,127	10
11	Sprinkler			1981	15,769		25			15,769	11
12	Ceiling - dining room			1982	3,621		10			3,621	12
13	Masonry - building			1982	15,200		10			15,200	13
14	Generator fixture			1982	7,967		10			7,967	14
15	Roofing			1983	28,000		10			28,000	15
16	Parking lot			1983	4,632		15			4,632	16
17	Painting			1983	14,000		5			14,000	17
18	Air-conditioner			1983	3,033		10			3,033	18
19	Leasehold Improvements			1984	40,296		10			40,296	19
20	Building Improvements			1985	28,578		10			28,578	20
21	Building Improvements			1986	14,578		10			14,578	21
22	Building Improvements			1987	7,225		10			7,225	22
23	Painting and decorating			1985	11,028		3			11,028	23
24	Sprinkler			1987	117,905		26	4,535	4,535	59,710	24
25	Building Improvements			1988	37,503		10			37,503	25
26	Building Improvements			1989	52,259		10			52,259	26
27	Building Improvements			1990	17,633	588	10	588		17,633	27
28	Building Improvements			1990	2,100	70	10	70		2,100	28
29	Building Improvements			1991	8,500	850	10	850		8,217	29
30	Building Improvements			1991	2,322		10			2,322	30
31	Building Improvements			1992	371,526	37,153	10	37,153		315,801	31
32	Building Improvements			1993	21,620	2,162	10	2,162		16,575	32
33	Building Improvements			1993	9,267	927	10	927		7,106	33
34	Building Improvements			1993	151,464	15,146	10	15,146		113,595	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 56,896		$ 192,128	$ 135,232	$ 2,751,428	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Leasehold Improvements			1994	118,383	11,838	10	11,838		78,672	9
10	Building Improvements			1995	20,792	2,079	10	2,079		11,782	10
11	New closets in rooms 150 and 180			1995	2,600	260	10	260		1,213	11
12	New 200 amp and 50 amp lines to activity room			1996	4,900	490	10	490		2,287	12
13	Construct office room in basement			1996	1,650	165	10	165		772	13
14	Roofing work			1996	95,112	9,511	10	9,511		44,384	14
15	Overbed tables			1997	3,537	354	10	354		1,298	15
16	Sprinklers			1997	8,367	837	10	837		3,069	16
17	Exiss observation system			1997	975	97	10	97		356	17
18	Fence post and rail			1997	1,885	188	10	188		689	18
19	Exhaust fan and stove			1997	8,143	814	10	814		2,986	19
20	Brick floor			1997	7,707	771	10	771		2,827	20
21	Wiring for telephones			1997	1,832	183	10	183		672	21
22	Fire alarm			1997	16,271	1,627	10	1,627		5,966	22
23	Piping			1997	821	82	10	82		301	23
24	Emergency lighting fixtures			1997	3,000	300	10	300		1,100	24
25	Wiring for exhaust fan			1997	1,610	161	10	161		591	25
26	Replacement door			1997	1,445	145	10	145		531	26
27	Therapy room			1997	6,116	612	10	612		2,244	27
28	Concrete			1997	895	90	10	90		330	28
29	Remodeling of physical and occupational therapy rooms			1997	268,920	26,892	10	26,892		98,604	29
30	Flooring			1997	585	58	10	58		213	30
31	Handrails: corner and bumper guards			1997	11,954	1,195	10	1,195		3,188	31
32	Fire alarm system improvements			1997	3,450	345	10	345		920	32
33	Ceiling tile			1997	3,985	398	10	398		1,063	33
34	New walls - therapy room			1997	2,982	298	10	298		795	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 59,790		$ 59,790	$	$ 266,853	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Signs			1997	1,713	171	10	171		457	9
10	Electric service			1997	1,700	170	10	170		453	10
11	Chain link fence			1997	3,100	310	10	310		827	11
12	Dining room ceiling			1997	2,000	200	10	200		533	12
13	Balance air conditioning system			1997	24,290	2,429	10	2,429		6,477	13
14	Video monitoring system			1997	1,932	193	10	193		515	14
15	Electric service			1998	3,250	325	10	325		867	15
16	Fire alarm system improvements			1998	2,625	263	10	263		700	16
17	Floor tiles			1998	3,598	360	10	360		960	17
18	Electrical work: install outlets, amp feeders			1999	16,737	1,674	10	1,674		2,789	18
19	Aquarium			1999	10,500	1,050	10	1,050		1,750	19
20	Hot water tanks			1999	5,132	513	10	513		856	20
21	Ceiling tiles			1999	2,689	269	10	269		448	21
22	Fabrication of 211 sleeves for fire dampers			1999	2,532	253	10	253		422	22
23	Two gold chandeliers			1999	4,193	419	10	419		699	23
24	Fire dampers installation			1999	5,083	508	10	508		847	24
25	Fire dampers installation			1999	1,641	164	10	164		274	25
26	Install new gas valves & gaskets on boiler			1999	4,173	417	10	417		452	26
27	Install new motor in water heater			1999	2,397	342	10	342		371	27
28	Install security cameras			1999	3,109	311	10	311		337	28
29	Furnish, wire & install lights in the main dining room			2000	2,640	132	10	132		132	29
30	Install 2 fan coils, water piping, drain & insulation			2000	4,300	215	10	215		215	30
31	Install new chiller			2000	1,925	96	10	96		96	31
32	Install handrails, wall bumpers & rubber cove base			2000	14,570	729	10	729		729	32
33	Install handrails, wall bumpers & rubber cove base			2000	5,904	295	10	295		295	33
34	Install corner guards			2000	1,616	81	10	81		81	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 11,889		$ 11,889	$	$ 22,582	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Vinyl tiles & rubber cove base			2000	1,875	94	10	94		94	9
10	Electrical work			2000	30,000	1,500	10	1,500		1,500	10
11	Install metal partition walls with drywall			2000	3,280	164	10	164		164	11
12	Generator installation			2000	3,610	180	10	180		180	12
13											13
14											14
15											15
16											16
17	Allocated from Management Company-See Attached Detail Schedule:				1,107						17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 1,938		$ 1,938	$	$ 1,938	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 622,870	$ 27,009	$ 27,009	$	10 years	$ 283,908	37
38	Current Year Purchases	146,886	7,344	7,344		10 years	7,344	38
39	Fully Depreciated Assets	633,083	786	786		5,7,10,11 yrs	633,083	39
40	Allocated from Mgt Company:	168,341		16,592	16,592		61,043	40
41	TOTALS	$ 1,571,180	$ 35,139	$ 51,731	$ 16,592		$ 985,378	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Care	1991 Dodge Caravan	1995	$ 27,331	$ 2,733	$ 2,733	$	5 years	$ 27,331	42
43	Patient Care	1996 Toyota Camry	1996	18,773	3,755	3,755		5 years	17,522	43
44										44
45	Allocated from Management Company:			14,827		3,138	3,138		11,585	45
46	TOTALS			$ 60,931	$ 6,488	$ 9,626	$ 3,138		$ 56,438	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 172,140	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 327,102	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 154,962	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,084,617	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 14,232 Description: Copier $7,920, Ice-maker $1,860, Postage meter $715, Generator rental $1,462, Mgt. Co. $2,275
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2001 Chrysler Town	$ 519.00	$ 2,290	17
18	Administrative	1999 Toyota Camry	326.00	4,237	18
19					19
20	Allocated from Management Company:			8,602	20
21	TOTAL		$ 845.00	$ 15,129	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,300		1,300
9	TOTALS	$	$ 1,300	$	$ 1,300
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,300			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	18
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	18

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln10a,Col 2&3	hrs	$	1,090	$ 44,679	$ 868	1,090	$ 45,547	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 2	hrs		237	9,714		237	9,714	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln10a,Col 2&3	hrs		1,230	56,577	783	1,230	57,360	4
5	Physician Care	Ln 39, Col 3	visits			1,280			1,280	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescrpts				168,095		168,095	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39, Col 2					99,277		99,277	12
13	Other (specify): Radiology & Laborato	Line10a, Col 3 Ln 39, Col 3			237	7,111 16,162		237	7,111 16,162	13
14	TOTAL			$	2,794	$ 135,523	$ 269,023	2,794	$ 404,546	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,006,942	$ 2,762,425	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 134,000)	2,247,227	3,803,843	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	113,938	113,938	6
7	Other Prepaid Expenses	13,745	13,745	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Loans Receivable	16,894	16,894	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,398,746	$ 6,710,845	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	200,000	200,000	12
13	Land		367,140	13
14	Buildings, at Historical Cost		4,058,341	14
15	Leasehold Improvements, at Historical Cost	1,270,566	1,768,565	15
16	Equipment, at Historical Cost	828,756	1,632,111	16
17	Accumulated Depreciation (book methods)	(1,182,985)	(4,084,617)	17
18	Deferred Charges		58,646	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	187,719	187,719	22
23	Other(specify): Mortgage Costs (Net)		198,937	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,304,056	$ 4,386,842	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,702,802	$ 11,097,687	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 246,216	$ 246,216	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	191,356	191,356	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,942	183,942	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,930	1,930	31
32	Accrued Real Estate Taxes(Sch.IX-B)		321,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule E:	2,694,532	2,694,532	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,317,976	$ 3,638,976	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,200,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,317,976	$ 3,638,976	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,384,826	$ 7,458,711	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,702,802	$ 11,097,687	48

SEE ACCOUNTANTS' COMPILATION REPORT *(See instructions.)

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Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,892,725	1
2	Restatements (describe):		2
3	**Prior Period Adjustments:**	316,573	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,209,298	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,986,930	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,811,402)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (824,472)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,384,826	24 *

* Operating Entity Only

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,897,842	1
2	Discounts and Allowances for all Levels	(1,501,973)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,395,869	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	378,340	6
7	Oxygen	504,464	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 882,804	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	275,593	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,043	19
20	Radiology and X-Ray	4,530	20
21	Other Medical Services	515,727	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 880,893	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	141,431	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 141,431	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,300,997	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,973,570	31
32	Health Care	3,762,635	32
33	General Administration	1,920,738	33
	B. Capital Expense		
34	Ownership	2,121,437	34
	C. Ancillary Expense		
35	Special Cost Centers	372,535	35
36	Provider Participation Fee	163,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,314,067	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,986,930	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,986,930	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,801	4,017	$ 126,183	$ 31.41	1
2	Assistant Director of Nursing	2,607	2,845	83,141	29.22	2
3	Registered Nurses	61,350	67,287	1,396,960	20.76	3
4	Licensed Practical Nurses	2,212	2,453	46,868	19.11	4
5	Nurse Aides & Orderlies	104,474	110,060	1,015,978	9.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,272	2,494	31,934	12.80	8
9	Activity Director	1,950	2,096	19,072	9.10	9
10	Activity Assistants	4,937	5,079	37,491	7.38	10
11	Social Service Workers	8,985	10,010	128,510	12.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,376	6,981	63,026	9.03	14
15	Cook Helpers/Assistants	33,235	35,282	274,207	7.77	15
16	Dishwashers					16
17	Maintenance Workers	9,495	9,935	115,205	11.60	17
18	Housekeepers	33,692	35,627	242,286	6.80	18
19	Laundry	15,962	17,180	128,368	7.47	19
20	Administrator	2,061	2,251	84,139	37.38	20
21	Assistant Administrator	1,465	1,643	48,612	29.59	21
22	Other Administrative	1,612	1,612	72,895	45.22	22
23	Office Manager					23
24	Clerical	13,338	14,016	419,740	29.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,005	2,091	19,403	9.28	31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	18,058	18,730	200,410	10.70	33
34	TOTAL (lines 1 - 33)	329,887	351,689	$ 4,554,428 *	$ 12.95	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,437	Ln 1,Col 3	35
36	Medical Director	Monthly	12,510	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,585	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	68	2,740	Ln 11, Col 3	44
45	Social Service Consultant	53	2,520	Ln 12, Col 3	45
46	Other(specify) Medical Librarian	16	880	Ln 10, Col 3	46
47	Religious Consultant	8	200	Ln 12, Col 3	47
48	Psychology Consultant	5	172	Ln 10, Col 3	48
49	TOTAL (lines 35 - 48)	150	$ 30,044		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45. ** See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sidney Glenner	Administrative		$ 31,617
Barry Ray	Administrative	0.00%	23,713
David Glenner	Administrative	0.00%	17,565
Simcha Dachs	Administrator	0.00%	84,139
Micky Vujanovic	Asst. Administrator	0.00%	48,612
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 205,646

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 320,146
TOTAL (agree to Schedule V, line 17, col. 3)	$ 320,146
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Health Data Services	Computers	$ 6,894
American Express/Frost,Ruttenberg	Accounting	41,832
Burke, Warren & MacKay	Legal	10,370
Sachnoff & Weaver	Legal	11,878
Littler Mendelson/Berton Goldstein	Legal	53,683
Esquire Deposition Services	Legal Deposition Services	2,587
The Weiss Group	401 K Consulting	1,079
Howard S. Chez & Associates	Engineering Consulting	5,465
Personnel Planners	Unemployment Consulting	1,002
Davidson Consulting	Inservice Nurses Evaluation	400
Cox, Ltd.	Fire Safety Evaluation	2,439
Commitment Consulting	A/R Collections	19,736
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 157,365

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,542
Unemployment Compensation Insurance	20,209
FICA Taxes	306,209
Employee Health Insurance	44,360
Employee Meals	23,030
Illinois Municipal Retirement Fund (IMRF)*	
Union Health and Welfare	55,394
Union Pension Fund	28,657
Profit Sharing, 401K Match	57,406
Employee Vaccinations	1,521
Employee Appreciation, Gifts	10,237
Uniform Allowance	2,585
Allocated from Management Company:	61,847
TOTAL (agree to Schedule V, line 22, col.8)	$ 667,997

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,689
Health Care Worker Background Check	
(Indicate # of checks performed 50)	350
Illinois Council on Long Term Care Dues	8,148
JCAH Accreditation Survey Fee	10,248
Cook County Certificate of Operation Fees	462
Secretary of State Annual Report	100
Village of Northbrook Elevator Inspection	330
Allocated from Management Company:	2,006
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,333

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	0
Seminar Expense	0
Allocated from Management Company:	1,806
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,806

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	1996	$ 15,307	3 years	$ 5,102	$ 5,102	$ 2,552	$	$	$	$	$	$
2	Painting & Decorating	1997	42,931	3 years	7,156	14,310	14,310	7,155					
3	Painting & Decorating	1998	1,592	3 years		266	530	530	266				
4	Painting & Decorating	1998	59,296	3 years		9,883	19,765	19,765	9,883				
5	Painting & Decorating	1998	4,969	3 years		828	1,656	1,656	829				
6	Repairs & Maintenanc	1998	14,360	3 years		2,393	4,787	4,787	2,393				
7	Painting & Decorating	1999	15,287	3 years			2,548	5,096	5,096	2,547			
8	Painting & Decorating	2000	45,159	3 years				7,527	15,053	15,053	7,526		
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 198,901		$ 12,258	$ 32,782	$ 46,148	$ 46,516	$ 33,520	$ 17,600	$ 7,526	$	$

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Facility Name & ID Number Glen Oaks Nursing Home # 0022111 Report Period Beginning: 1/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $8,148**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,020** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **163,152**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **23,030** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

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